CONTRACEPTIVE CARE FOR TEXAS TEENS: ACCESS, ADVOCACY, AND ADJUDICATION

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TC 660H
Plan II Honors Program
The University of Texas at Austin

December 4, 2018

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ABSTRACT

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Title: Contraceptive Care for Texas Teens: Access, Advocacy, and Adjudication

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My thesis examines the landscape of contraceptive care for adolescents in Texas. While barriers to receiving sexual and reproductive health services have been identified, there is limited research focused on how these barriers manifest at the state level. In my work, I pay special attention to Texas, a state where policies restrict the level of confidentiality guaranteed to minors. This mixed methods project has three distinct elements. The first part of my thesis assesses existing literature on adolescent access barriers to contraceptive services in the United States from the last decade. I synthesize these findings in a systematic review which examines the experiences of both adolescents seeking these services and healthcare providers delivering these services. In this review, I discuss four major types of barriers to obtaining contraception that adolescents must navigate: finances, family, providers, and health systems. The second portion of my thesis involves qualitative data analysis from interviews with key informants in the Austin and Houston areas. These interviews feature the perspectives of those working within the arena of adolescent contraceptive service delivery in Texas. This dataset highlights recent changes in the Texas healthcare system and points to specific state-level challenges that impact the provision of contraception to minors. In the third and final part, the project culminates in an analysis of state policy, with recommendations for how health services might be improved for adolescents in Texas.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my supervisor Dr. Abigail Aiken whose guidance and endless reassurance motivated me to explore my interests in this way and encouraged me to follow through on my ideas. I would also like to acknowledge Dr. William Winslade for supporting me as my second reader in this endeavor, providing words of reassurance, wisdom, and critique along the way. Also integral to the success of this project are the 8 individuals who were generous and kind enough to allow me to interview them about their experiences. I greatly appreciate their eagerness to share their expertise and insight as healthcare providers. Another tremendous thank you goes to the Leslie Dyess Blanton Scholarship, which provided a generous thesis grant for this project. I am so grateful to the Plan II Honors Program, and specifically to Dr. Janet Davis, Dr. Richard Reddick, and Kaitlin Shirley for supporting students like me. Finally, thank you to my friends, family, and partner for spending countless hours on the phone and in coffee shops with me during this past year.

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INTRODUCTION

Access to sexual and reproductive health services allows individuals to make informed decisions about childbearing, avoid unintended pregnancies, and reduce adverse maternal and child health outcomes. In the United States, there are about 38 million women of reproductive age (aged 13-44) who need contraceptive services and supplies.[1] About 2.5 million adolescent women aged 15-19 reported current use of contraceptives in the 2011-2013 National Survey of Family Growth.[2] In Texas specifically, over 400,000 women under the age of 20 needed publicly funded contraceptive services and supplies in 2014.[3] It is important to understand the barriers that face adolescents who seek contraceptive services in Texas and the United States as a whole. The gravity of reproductive health decisions cannot be understated—unintended pregnancies could potentially affect one's physical health, emotional well-being, economic prospects, and livelihood. The overarching goal of this project will be to understand adolescents' experiences accessing contraceptive services in Texas and pinpoint the most significant barriers they may face. The primary focus of this work will be the role of recent state policies in moderating the provision of contraception to adolescents and addressing statewide adverse health outcomes.

This project uses a combination of in-depth literature review and examination of experiential narratives from providers and administrators to explore the extent of unmet need among adolescent patients and to identify areas in which policy improvements may be made. Both the systematic literature review and semi-structured interviews emphasize Texas in order to understand how contraceptive service delivery operates for adolescents given the unique geographic, political, and socioeconomic climate in this state. This thesis project will also examine issues of medical ethics, such as medical decision-making for minors, as well as feminist deconstructions of teen pregnancy prevention initiatives. Overall, this project seeks to

offer new insights into how the Texas health care system serves its adolescents and thus addresses or contributes to pervasive health outcomes. My discussion will emphasize the ways in which all aspects of sexual and reproductive health feed into one another and highlight existing health inequities among adolescents in Texas.

SECTION ONE

Reproductive Health: The Context of Contraceptive Need

Discussions of reproductive health services and service utilization among adolescents require an initial understanding of contraceptive need. There are approximately 61 million women of reproductive age in the United States.[4] Of these women, more than half use a contraceptive method. These methods vary widely in terms of both efficacy and cost. Contraceptive users have primarily relied on the pill and tubal sterilization since 1982.[5] However, an increasing number rely on long-acting reversible contraceptives (LARCs) such as intrauterine devices and implants. 7.2% of women aged 15-44 reported LARC use in 2011-2013, compared to 3.8% in 2006-2010.[6] In addition, methods of emergency contraception prevent pregnancy following unprotected sex or suspected contraceptive failure. The use of emergency contraception falls into a different category all together, considering a majority of women use this method only once.[7]

One in ten women at risk of unintended pregnancy do not use a contraceptive method, and this proportion nearly doubles among adolescents 15-19 years of age.[8] In fact, unintended pregnancies account for 75% of all pregnancies that occur among adolescents between the ages of 15-19.[9] On a global scale, rates of teen pregnancy have declined rapidly over the last several decades. In 2016, the U.S. birth rate among adolescents aged 15-19 fell to a record low of 20.3 live births per 1,000 females.[10] According to the Pew Research Center, contributing factors such as less sexual intercourse among adolescents, a greater use of highly effective contraceptive methods, and more widespread information regarding pregnancy prevention may explain these declining birth rates.[11,12]

Although significant progress has been made towards reducing the incidence of teen pregnancy in the United States, there are still geographic, socioeconomic, and racial/ethnic disparities that persist. Southern states, including Texas, continue to have the highest rates of teen pregnancy and teen birth in the country.[13] Research indicates that teens in southern part of the United States experience more adverse sexual health outcomes and higher rates of unsafe sexual behaviors compared with average national indicators.[14] In addition, black and Hispanic adolescents have rates of teen birth that are more than twice those of white and Asian/Pacific Islander adolescents.[15]

Reproductive Rights as Human Rights

A pivotal moment in the reproductive rights discourse occurred in 1994 at the United Nations International Conference on Population and Development (ICPD) in Cairo. This conference emphasized the importance of reproductive health for women and girls across the world and expanded the international human rights framework to include reproductive rights. [16] Leaders affirmed the central belief that personal autonomy and gender equality are not achievable without the safeguarded ability to decide whether and when to reproduce. All 179 UN member states in attendance, including the United States, endorsed a Programme of Action that stressed individual rights and an investment in women and youth. Although family planning programs had been emphasized at the international level prior to this conference, the 1994 ICPD was a discursive shift from Malthusian notions of population control to the promotion of individual reproductive rights. Moreover, the Programme of Action outlined specific commitments to adolescent sexual and reproductive health, including the support of contraceptive services for sexually active, pregnant, and parenting adolescents.

Key Supreme Court Cases

Although the United States signed on to address issues of reproductive and sexual health among adolescents, unenforceable international conventions such as the Programme of Action do not always achieve compliance in practice. A series of prior U.S. Supreme Court cases demonstrate the ongoing ambiguity of legally-recognizable reproductive rights for minors. In 1965, the Supreme Court recognized a constitutional right to marital privacy in its ruling for *Griswold v. Connecticut*. The Supreme Court decision defended a married couple's right to use contraceptives, proclaiming its basis was in the penumbra of constitutional protections that sought to guarantee privacy.[17] Extending this decision further, the *Eisenstadt v. Baird* ruling in 1972 struck down the ban on contraceptives for single individuals, noting that the right to privacy meant "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[18] Just one year later, the pivotal *Roe v. Wade* case challenged a Texas restriction on abortions. In their decision, the Supreme Court Justices acknowledged the State's interest in potential life and maternal health while asserting that a pregnant person has the right to terminate that pregnancy on the basis of individual autonomy and personal privacy.[19]

Cases recognizing adolescents' reproductive rights on a federal level were still to come. In 1976, the *Planned Parenthood v. Danforth* case challenged a Missouri state law that stipulated adolescents had to obtain parental consent prior to receiving an abortion. The Supreme Court ruled that the state's interests do not justify requiring parental consent in the case of a minor's abortion. However, the ruling also clarified that pregnant adolescents' right to privacy in medical decision-making is contingent on their competency.[20] Although it would seem that this Supreme Court case safeguarded adolescents' right to seek health services for themselves, the *Belloti v.*

Baird ruling just three years later in 1979 would allow state restrictions such as mandatory involvement of parents and judges in the abortion decision-making process.[21] With regards to contraception, the *Carey v. Populations Services International* (1977) decision upheld minors' right to privacy by striking down a ban on nonprescription contraceptives for minors under the age of 16. The majority opinion written by Justice William Brennan noted that burdensome restrictions on the provision of contraceptives deprive individuals of the freedom to make reproductive decisions.[22] This landmark case further underscored that minors are endowed with the same constitutional protections as adults, while recognizing the authority of states to regulate minors more broadly than adults. The decision rejected the use of age requirements in favor of reproductive capacity to govern one's access to contraceptives.

Overall, these cases demonstrate the ways in which federal law links reproductive autonomy with the negative right of privacy rather than notions of justice or equality. This decision to ground reproductive rights in privacy rather than a government's interest in gender equity or reproductive autonomy is significant. Not only does this legal framework stand in stark contrast with the ICPD's discourse around reproductive health in the years that followed, but it also introduced unique challenges to the reproductive rights movement that continue today. In an article for *The New Yorker*, American historian Jill Lepore noted that "When the fight for equal rights for women narrowed to a fight for reproductive rights, defended on the ground of privacy, it weakened."[23] Not only has the so-called "privacy doctrine"[24] in defense of reproductive rights been criticized for its failure to address the issue of discrimination against women, but it has also made reproductive rights susceptible to overrule by the argument for religious liberty in later cases such as *Burwell v. Hobby Lobby* in 2014. In this pivotal Supreme Court case, the Affordable Care Act's mandate for employer insurance coverage of contraception was struck

down because representatives of the for-profit corporation Hobby Lobby claimed that the mandate infringed upon their religious liberty.[25] The Court's ruling in the *Burwell v. Hobby Lobby* case is illustrative of the fact that, legally speaking, reproductive rights rest on shaky ground.

Adolescent Medical Decision-Making

Despite the Supreme Court's rulings on the right to privacy, and the extension of these rulings to apply to minors, there is a large amount of variation in state laws governing these rights. The patient-centered model of healthcare emphasizes the role of the patient in making important medical decisions. However, parent guardians generally retain control over the decision-making for patients under the age of 18. Regarding adolescent reproductive health, notions of self-determination and stigma often complicate the situation. In the last several decades, the rights of minors to consent to reproductive health care have grown significantly. However, the policies regarding adolescent decision-making remain varied across states. While at the federal level, a minor might be ruled capable of making reproductive decisions on their own behalf, adolescent medical decision-making processes are often shaped by state laws dictating access to care. A lack of standardization means that geographical location is often the biggest determinant of one's right to privacy as an adolescent. For example, more than half of states permit all pregnant minors to consent to prenatal care.[26] Other states have certain age requirements or stipulate that the minor must be "mature enough."[27] Still others allow physicians to notify the minor's parents or lack a policy altogether.

When it comes to contraceptive access, policies are even less consistent. Nearly half of states permit all minors to consent to contraceptive services while the rest have policies that

restrict this decision-making to particular circumstances. These circumstances range from emergencies, pregnancy, marriage, or fulfillment of set requirements such as high school graduation, age limits, or demonstrated maturity.[28] For instance, a pathway known as the mature minor doctrine extends the judicial bypass opportunity available for minors seeking an abortion to other medical decisions depending on the circumstances. Past court cases in states like Illinois, Tennessee, and Maine have asserted that there exists a common law right to consent to (or refuse) medical treatment, so the mature minor doctrine allows judges to decide whether or not a minor has the capacity to make medical decisions for themselves. This legal pathway seeks to balance state interests with the right of mature minors.[29] The doctrine allows some minors to make decisions if they are at least 14 years of age, able to give informed consent, and benefit from the decision without any great risks.[30] Despite the groundbreaking nature of this doctrine, most states in America will not allow even mature minors to consent to medical care, requiring parental consent in a majority of contexts.[31] For instance, the Texas Court of Appeals rejected the use of the mature minor standard in 1990.[32] For those states that do subscribe to the mature minor doctrine, it still presents an inadequate solution to the situational nature of competency in context. Minors wishing to make medical decisions for themselves must undergo an appeals system and prove their maturity to a judge. Without a clear indication of competency criteria, the system places the onus on adolescents by granting the state court full discretion in its determination of competency. Rather than empowering competent adolescents to make medical decisions for themselves, the doctrine transfers most of the agency to the court judge.

A Brief History of Family Planning Services

Notwithstanding the ambivalent legality regarding minors' medical decision-making, federal family planning programs have historically allowed minors access to reproductive health services on their own. Medicaid started out as a safety-net program for low-income women and their children. Since its inception in 1965, the Medicaid program has broadened its eligibility requirements to include pregnancy and some family planning services. When Congress passed Title X with bipartisan support in 1970, it took the first step toward the creation of a federal support system dedicated exclusively to family planning services. Since its inception, the Title X program has granted women the ability to avoid unintended pregnancy and access key reproductive health services.

Operating out of the Office of Family Planning within the domain of the federal Department of Health and Human Services, Title X provides block grants to family planning clinics around the country. The diversity of grantees is a major contributor to the success of the program—agencies are able to structure their services to meet the needs of local populations whom they serve.[33] Community-based organizations, rural clinics, and school-based health centers can each address distinct health needs. A 1995 survey of publicly funded family planning agencies documented that an overwhelming majority of providers use federal funding.[34] Furthermore, these agencies serve clients who predominately fall near or below the federal poverty level.[35] Planned Parenthood affiliates make up a large part of this network of federally-funded family planning providers. With over 600 health centers in the U.S., Planned Parenthood provides sexual and reproductive health services to 5,400,000 clients annually.[36]

It is important to note the reasoning behind a federally-funded family planning service. Congress understood the prevention of unintended pregnancies as a worthwhile goal, in terms of

both health outcomes and cost efficiency. Simply put, there is a great need for publicly funded contraceptive services, particularly for low-income people and adolescents. Two primary reasons are the cost of contraceptive services and the need for confidentiality when seeking these services. Avoiding unintended pregnancies and reducing the prevalence of STIs and HIV/AIDS is also important for both federal and state governments in terms of public expenditures. Family planning programs are cost-effective, saving an estimated $7 in Medicaid costs for every $1 invested.[37] Together, public programs such as Medicaid and Title X provide access to contraceptive services for approximately 6.2 million women.[38]

With the initial establishment of family planning programs, policymakers also recognized the right of Americans to "exercise personal choice in determining the number and spacing of their children."[39] The Title X program sought to expand voluntary services to decrease unintended pregnancies as well as other comprehensive healthcare services such as cancer screening, pregnancy counseling, STD/HIV testing, and postpartum care. Congress later clarified that these services should also be provided to adolescents and that adolescents should be encouraged but not required to consult their parents about family planning.[40] In this regard, the Title X grant program prohibits parental notification requirements, guaranteeing confidential access to services for adolescents. Although for most medical decisions, minors must defer to their parents' judgment, the decision-making framework for family planning services differs. Federal and state policies allow for exceptions to competency requirements for some adolescent health services and not others primarily on the basis of public health interest. Governments wish to ensure that adolescents can receive basic services such as STI testing and contraception care without the impediment of stigma or parental refusal. As a result, Title X and Medicaid allow adolescents to receive family planning services confidentially in order to protect these patients.

Moreover, adolescents in states like Texas can bypass policies against confidential care by going to federally-funded Title X clinics.

Reproductive Health Policy Trends

In March 2010, Congress enacted the Affordable Care Act (ACA), seeking to expand health insurance coverage for low-income, uninsured, and under-insured Americans.[41] The ACA established an essential health benefits package that emphasized preventive care and broadened coverage for reproductive health services such as contraception. Now, under federal law, health insurers must cover the full range of FDA-approved contraceptive methods without out-of-pocket costs. Studies show that ACA expansions to Medicaid eligibility increased insurance coverage and access to services for adolescents.[42]

In addition to the expansion of insurance coverage, a provision of the ACA increased funding for school-based health centers (SBHCs). SBHCs are located on or near school campuses and provide primary health care services with a focus on prevention and risk reduction. For students across the country, SBHCs increase access to key sexual and reproductive health services. An article published in the Journal of Adolescent Health notes that these health centers are a key point of entry for students to accessing reproductive health education and care.[43] Currently, around 20% of SBHCs operate with federal funding; however, many of these centers must follow state and local policies that restrict their provision of contraceptive services.[44] As originally passed, the ACA required states to expand Medicaid coverage or lose federal funding for Medicaid entirely; however, the Supreme Court overturned the mandate, allowing states to make the decision for themselves. Some states, including Texas, refused the ACA Medicaid expansion.

Furthermore, in June 2018, the Trump administration issued a proposal for changes to the Title X program that would have drastic impacts on the types of services offered and the network of Title X grantees. The so-called "domestic gag rule" would prohibit Title X clinicians from making referrals to abortion services for patients and exclude from the program providers like Planned Parenthood who offer abortion as part of their spectrum of services .[45] The proposal also seeks to prioritize abstinence, adoption, and fertility awareness-based methods such as natural family planning over medical contraceptive services. Finally, clinicians would be required to "document their efforts to encourage the [minor] patient to involve parents or guardians in their decision-making, or document why such participation was not encouraged."[46] This last component of the proposal poses challenges to the principle of confidentiality under which the Title X program was originally created. It is unclear whether or not these changes will go into effect, what the exact timeline might look like in the event that they are approved, and what legal battles might be waiting for the U.S. Department of Health and Human Services in the near future. However, several organizations representing healthcare providers have already cited their opposition to the Title X proposal on the basis of its restrictions to Title X access, encroachment upon the provider-patient relationship, and weakening of confidentiality protections among others.[47]

State-Specific Concerns: The Case of Texas

While federal family planning programs like Title X enable large portions of the population to receive sexual and reproductive healthcare, individual state policies can also have an immense impact on one's ability to access these services. Some research points to an association between state policy and teen childbearing outcomes. One review of existing studies

on this relationship found that legislation that supports minors' access to contraception and increases funding for family planning through state expenditures and Medicaid waiver policies is associated with overall lower teen birth rates.[48] Despite having the highest percentage of uninsured residents of any state in the country,[49] Texas legislators have a history of opting out of receiving federal funds on ideological or political grounds. Seeking to prevent public funding from being awarded to Planned Parenthood, legislators banned facilities that provide abortion or are affiliated with abortion providers from participating in a federally-matched Medicaid waiver program, known at the time as the *Women's Health Program* (WHP).[50] These changes contradicted federal policy, which stipulates that clients must have a free choice of provider; as a result, the Centers for Medicare and Medicaid Services (CMS) denied the renewal of funding for WHP, resulting in a loss of federal matching funds that previously covered 90% of the program's costs.[51] The changes followed severe cuts in 2011 when Texas legislators reduced funding for the state's family planning program by two-thirds.[52]

Texas' family planning program, Healthy Texas Women, now runs without Medicaid funding and by extension without federally-funded safety-net programs that provide contraceptive care. These changes caused significant and almost instantaneous damage to the state's family planning infrastructure. A quarter of family planning clinics in Texas closed following these 2011 legislative changes.[53] Coupled with clinic closures, funding constraints also resulted in a reduction in clinics' overall capacity to provide services. As a result, the number of clients served by these programs fell by 54%.[54] A growing body of literature focuses on the aftermath of this particular legislation, examining subsequent health outcomes and service accessibility. These studies indicate that the reduction of family planning programs increased costs for patients as well as organizations with regards to family planning services.[55] Moreover,

with only 269 physicians per 100,000 population, Texas has the lowest ratio of physicians to patients of any state.[56] In this regard, the lack of clinics and the limited healthcare workforce in Texas amplify the effects of these coverage gaps.

Currently, Texas seeks to re-apply for federal funding of the HTW program.[57] If CMS approves Texas' request, it will set a new precedent for programs that violate Medicaid policies such as the exclusion of family planning providers associated with abortion (even when none of the public funding can be used to provide abortion services) and the requirement that minors obtain parental consent prior to receiving publicly funded family planning services.[58] Although the outcome of this request will likely not change access to reproductive health services for adolescents in Texas, it presents a future policy concern for adolescents in other states that may wish to follow Texas' lead.

Issues Facing Adolescents in Texas

Most adolescents in Texas do not receive comprehensive sex education. While 25% of public school districts have no sexuality education at all, almost 60% of districts employ abstinence-only programs.[59] In fact, Texas has rejected millions of dollars in federal funds for the Personal Responsibility Education Program, an initiative to educate teens about contraception in addition to abstinence.[60] However, even Texas teens who are educated about contraceptive methods face significant challenges to receiving contraceptive care. State policies in Texas are relatively restrictive when it comes to adolescent reproductive health. A combination of religiosity and stigma hinder the ability of minors to access reproductive health services. The state will only allow minors who are married to consent to contraceptive services—these minors achieve emancipation after marriage and are thus guaranteed under state law all of the rights and

responsibilities of adults. In addition, Texas is one of two states that does not allow state funding of confidential contraceptive services for minors, except for a couple of exemption categories.

Since laws surrounding confidentiality directly contradict federal policies, each program has a different policy depending on its funding stream. For example, the Children's Health Insurance Plan (CHIP) falls within the purview of state law and does not provide coverage for contraceptive services for the sake of family planning. On the other hand, the federal Medicaid program covers confidential contraceptive services for adolescents in accordance with federal policy. However, it is relevant to note that few adolescents are covered by federal Medicaid due to Texas' decision against the expansion of Medicaid statewide.[61] A subset of Medicaid, known as Medicaid for Pregnant Women allows patients to access Medicaid benefits until two months postpartum for services including prenatal care and LARC placements.[62] In addition, adolescents between the ages of 15 and 18 can apply for the state-run Healthy Texas Women program but must have parental consent to do so.[63] Healthy Texas Women provides no-cost family planning services, including LARC methods, for low-income women who are eligible.[64] The afore-mentioned Title X clinics use federal family planning funds that guarantee patient confidentiality to all patients (including minors). Healthcare facilities that serve patients on Medicaid must comply with federal requirements as well. These inconsistent restrictions on contraceptive services can be difficult for providers to grapple with, let alone adolescents unfamiliar with the policies. Particularly after many family planning clinics lost funding following 2011-2013 state policy changes, adolescents may find confidential access to contraception to be scarce.

When the provision of contraception services is not confidential, it discourages adolescent patients from receiving care. One study published in the Journal of Adolescent Health early this year found that adolescent girls and young women with confidentiality concerns are

less likely to receive contraceptive care.[65] Yet in Texas' state-funded family planning program, minors must obtain their parents' permission in order to receive prescription contraception. Texas policies on contraception are worth investigating, given that the state of Texas has some of the highest rates of teen and repeat teen pregnancy as well as pervasive health disparities and socioeconomic inequality. Although Supreme Court cases ruled in favor of a constitutionally protected right to privacy in reproductive decision-making for minors, Texas still grapples with the concerns of parents, lobbyists, and stakeholders who oppose widespread use of contraception. As a result, adolescents continue to face significant barriers impeding their access to contraceptive methods. In the next section, I will explore these access barriers and their consequences in detail through a systematic review.

SECTION TWO:

SYSTEMATIC REVIEW OF ACCESS BARRIERS TO CONTRACEPTIVE SERVICES

I. Purpose

The national teen pregnancy rate has dropped significantly in the last decade, yet the United States maintains the highest rate among its peer nations.[66] Some research points to the increased use of contraception methods as one of the primary reasons for the decline in teen pregnancy.[67] While some adolescents who seek contraceptive services may be able to meet their needs without difficulty, many more continue to face access barriers. A significant body of research recognizes the importance of adolescent sexual and reproductive health services, yet there is a lack of consensus on the exact access barriers facing adolescents who seek contraceptive services. Some research explores pregnancy intention and attitudes towards contraception, with findings that suggest adolescents may experience ambivalence about pregnancy or perceive a lack of reproductive autonomy.[68] Other studies explore the level of contraceptive knowledge among adolescents. For example, a 2013 study concluded that adolescents and young adults demonstrate an overall lack of contraceptive knowledge based on survey results.[69] While a large body of literature focuses on why adolescents may not seek out these services, my review will investigate the most significant factors preventing adolescents who seek contraceptive services from receiving these services. Many studies have explored access barriers to contraceptive services in the last decade; however, comprehensive review of this literature is warranted. This review synthesizes these studies' findings in order to provide a better understanding of the roadblocks preventing American adolescents from receiving the services they seek.

II. Theoretical Framework: Health Care Access Barriers (HCAB) Model

One model by Carrillo et al., the Health Care Access Barriers Model (see Figure 1), outlines the ways in which financial, cognitive, and structural barriers contribute to poor health outcomes and health disparities. While cognitive barriers, such as a patient's level of health education and attitudes towards contraception, may act as mediating factors in the receipt of contraceptive services among adolescents, the focus of this review is on the financial and structural challenges adolescent face when seeking contraceptive services. A variety of access barriers impact the ways in which adolescents obtain contraceptive care services and can contribute to overall decreased prevention and care. The following chapter explores these barriers and discusses which barriers might play the most prevalent role in contraceptive service delivery for adolescents in the United States, with special attention paid to how these barriers manifest at the state level in Texas.

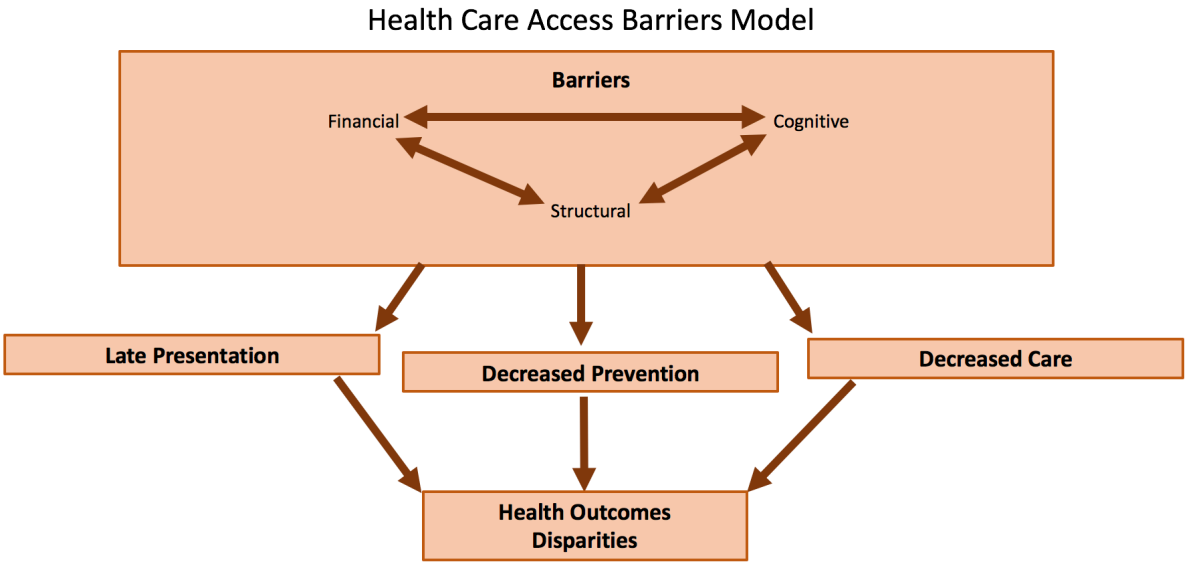

Figure 1. Health Care Access Barriers (HCAB) Model, adapted from Carrillo et al., 2011

III. Methods

This review included peer-reviewed English language publications published from 2009-2018. Articles were retrieved and compiled from the following six databases: PubMed, CINAHL, MEDLINE, PsycINFO, SocINDEX, and Health Source (Nursing/Academic). Key search terms included *minor, adolescents, adolescent, birth control, contraception, contraceptive, family planning, pregnancy, pregnant,* and *teen*. See Appendix 1A for a more detailed outline of the search strategy. Articles were included if they met the following criteria: data analysis limited to the United States; sample included either adolescents aged 13-18 or health care administrators and providers who serve adolescent patients; and data contained direct participant input concerning potential barriers to contraceptive services. This review also excluded grey literature such as conference proceedings, policy statements, and committee reports. Since adolescents seek emergency contraception in unique contexts from those in which they seek other contraceptive methods, studies focused on emergency contraception were excluded for the purposes of this review. Furthermore, publications were excluded if their research questions were outside the purview of access to contraceptive services such as adolescent sexual behaviors, patterns of contraceptive use, or pregnancy outcomes. A total of 670 unique articles met the search terms, and 29 articles met the specified inclusion criteria. The reference lists from these articles were then examined, yielding 5 additional papers. See Figure 2 for a diagram of the systematic review procedure.

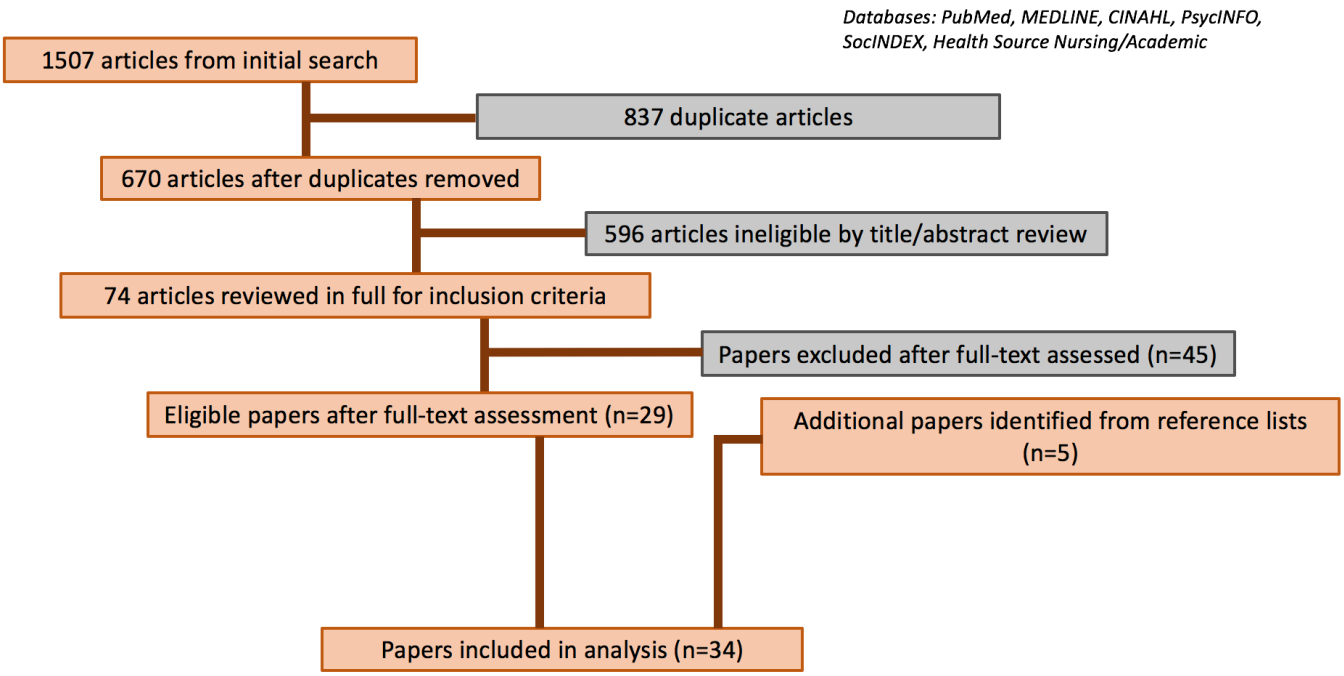

Figure 2. Diagram of systematic review process

IV. Findings

These studies indicate that the primary access barriers facing adolescents fall into four categories: provider barriers, health systems barriers, financial barriers, and family barriers. Provider barriers were those challenges involving the healthcare providers themselves, whether as a result of counseling decisions, the prioritization of certain contraceptive methods, use of overly restrictive eligibility criteria, or a lack of training. Some provider barriers were also based on the adolescents' perceptions of their relationship with their providers, such as a lack of teen-friendly staff, mistrust, or fear of judgment from their provider. Health systems barriers describe the lack of resources at the systemic level to deliver contraceptive methods to adolescent patients. These barriers include administrative paperwork, issues managing contraceptive supply, delays in appointment scheduling, and difficulties filling prescriptions that could prevent

adolescents from obtaining contraception. While provider and health systems barriers make up a substantial part of the access barriers for adolescents, financial barriers also played a pivotal role. Insurance coverage and cost were often cited within this category. Finally, family barriers surfaced as perhaps the most pervasive barrier in this literature review. The primary example of this individual patient barrier was reported concern about confidentiality and parent involvement in contraceptive decision-making.

Provider Barriers

In contraceptive service delivery, health care providers serve as gatekeepers between adolescents and contraception. Thus, in addition to navigating upfront costs, mediating parental involvement, and obtaining health services, adolescents must find a provider who is willing and able to deliver the service. It is providers who determine which patients fulfill eligibility criteria for contraceptive methods, take the lead on contraceptive counseling, and balance the different needs and concerns of their adolescent patients.

Provider Attitudes, Knowledge, and Training

A significant amount of research has investigated the role providers play in access and use of contraception among adolescents. Recently, researchers have shifted their focus to analyzing providers' perspectives of long-acting reversible contraceptive (LARC) methods such as intrauterine devices (IUDs) and implants. A 2013 study examined the perspectives of 28 primary care physicians from New York in interviews about contraceptive counseling.[70] Findings suggest that while these PCPs may utilize patient-centered contraceptive counseling generally, counseling about IUDs in particular occurs in a more paternalistic manner. Providers may make assumptions about the ineligibility of their adolescent patients, ultimately hindering access to

IUDs. Some studies in this review explored the ways in which outdated assessments of adolescent risk factors result in a wide variation of eligibility criteria, subsequently restricting some adolescents' access to contraception.

Although the American College of Obstetrics and Gynecology (ACOG) published a Practice Bulletin in 2011[71] that recommends IUDs for use in adolescents and nulliparous women, research indicates that providers continue to hold attitudes and beliefs contrary to these recommendations.[72,73] For example, a study published in 2017 found that most pediatricians were unsupportive of adolescent IUD use and excluded this method in their day-to-day contraception counseling for patients. Moreover, staff attitudes and beliefs can influence how clinics approach reproductive healthcare for adolescents. In a 2016 study by Hallum-Montes et al., leadership and staff in 16 health centers perceived providers as being uncomfortable addressing reproductive health needs for younger patients.[74] Staff from southern states in the sample (including Alabama, Georgia, and South Carolina) explained this discomfort as the result of religious beliefs surrounding contraceptives.[75]

Other studies reported similar findings, where provider concerns and attitudes towards certain contraceptive methods reflected a lack of accurate knowledge about the appropriateness of these methods for adolescents and the perceived likelihood of tolerability and/or adherence.[76,77,78] One 2013 study even pointed to the provider's background and training as a predictor of LARC provision.[79] When taking a survey regarding the provision of LARC, providers with women's health training were somewhat more likely to provide implants but much more likely to provide IUDs compared to providers with pediatrics or internal medicine backgrounds[80] (Greenberg et al., 2013). Particularly with regards to LARC methods, providers require adequate training and experience in device insertion in order to effectively counsel their

patients and place LARCs. A 2017 study found that several pediatricians routinely referred patients to another provider even when patients specifically requested IUDs and ENG implants, often citing discomfort or lack of experience with on-site placement of LARC methods.[81]

In another study, Murphy et al. explored intersecting provider barriers. Findings suggest that confidence in LARC, patient-centered counseling, and instrumental supports such as training to the providers' ability to practices and attitudes toward LARC provision.[82] Similarly, research indicates that there exist urban-rural differences among family planning providers' provision of contraception. In a 2012 study examining providers within Title X clinics in Texas, researchers concluded that a lack of insertion training among providers presented a key barrier to the provision of contraception, particularly among rural area providers.[83] Furthermore, only 54% of rural providers stated that they would be willing to recommend LARCs to adolescent clients aged 15-19 years, compared with 76% of their urban counterparts who reported willingness.[84] Crucial to understanding the landscape of contraceptive service delivery in Texas, this study found that key provider barriers include a lack of training and misinformation about eligibility criteria as well as side effects of LARCs.

Patient-Provider Communication, Fear of Provider Judgment

Findings from a focus group study of primary care providers by Akers et al. underscore these provider barriers, adding that providers sometimes make assumptions about their patients' pregnancy risk and fail to initiate sexual health conversations with patients.[85] Challenges in patient-provider communication as it relates to contraceptive counseling were presented in another study. Hoopes et al. interviewed 24 adolescents who discussed experiences with their medical providers in a 2017 qualitative study.[86] Findings suggest that interpersonal dynamics between adolescent patients and their providers may play a major role in discussions surrounding

contraception. Adolescent participants most often reported discomfort, concerns about provider judgment as well as a lack of trust and confidentiality in discussing experiences with their health care provider. These barriers were also seen in a 2015 study, where anticipated provider disapproval operated as a barrier to use of family planning services by adolescents in Boston, Massachusetts.[87] Moreover, when Galloway et al. led focus groups with 63 adolescents in South Carolina, participants often discussed the importance of a friendly, open environment at clinics in order to foster communication about contraception and sexual health.[88]

Health Systems Barriers

Some studies found that systemic barriers can impact contraceptive service delivery. For adolescent patients, navigating the complexities of health insurance, making and keeping appointments, and filling prescriptions can pose additional burdens. Moreover, clinical capacity to serve adolescents and provide patients with contraceptive options can be limited to the financial and logistical ability to stock various methods.

Appointments and Refills

Other studies explored the ways in which the logistics of health systems made accessing contraception difficult for adolescents. Coles et al. examined unintended birth in a national sample of adolescents (n=9779), pointing to contraceptive access issues as contributory factor in contraceptive nonuse. In this study, teens who experienced difficulties obtaining contraception increased their risk of unintended birth more than twofold, particularly among older adolescent age groups.[89] One common access barrier cited was the inability to receive medication due to a missed appointment or failure to get a refill on birth control.[90] These findings were echoed in a

similar 2016 study conducted by Conroy et al., which interviewed adolescent mothers (n=31) at an urban clinic in Massachusetts.[91]

Reimbursement and Funding for Clinics

One of the key access barriers at the health systems level is the ability of a given clinic to stock LARC devices. In a 2016 study on the implementation of evidence-based clinical practices at reproductive health centers, some staff of federally-qualified health centers and private practices reported a reluctance to provide counseling on LARC methods due to the expense of these methods.[92] Findings from another study also indicated that providers face financial challenges to stocking LARC devices such as delayed reimbursements.[93] Moreover, a 2015 study on school-based health centers in Seattle found that expense and billing make up a large proportion of administrative barriers, particularly for the confidential services provided at these centers.[94] Likewise, in a study conducted by Hallum-Montes et al., Texas senior administrators discussed difficulty collaborating between health centers, citing heightened competition and divisiveness following a rejection of Title X funding at the state level.[95]

Competing Priorities, Time Management

Providers in one study discussed limited time with patients as a barrier to effective contraceptive counseling.[96] Findings also suggested that clinical care systems do not adequately prioritize the provision of contraceptive counseling or pregnancy risk assessments in primary care.[97] In another study, some primary care providers even expressed concerns about losing patients via family planning referrals.[98] In a 2017 study by Berlan et al., 23 pediatricians from a city in the Midwest were interviewed about long-acting reversible contraceptives. Frequently, these participants cited time constraints in counseling as influential in determining whether or not IUDs and/or ENG implants were included in their routine contraceptive conversations with

patients.[99] Furthermore, participants in one study cited a lack of community support and awareness of these services for adolescents as a barrier to implementation of evidence-based clinical practices.[100]

Financial Barriers

Insurance and Cost for Patients

Studies in this review indicate that adolescents often experience difficulty affording or qualifying for care and services. One study utilized 8 focus groups of physicians, nurses, and pharmacists (n=48) from the University of Pittsburgh Medical Center to investigate barriers to contraceptive counseling and found that many providers discussed adolescents' lack of insurance coverage for contraception as a primary health systems barrier.[101] Another study, conducted by Wilson et al., examined the postpartum contraceptive use of adolescent mothers (n=21) in North Carolina.[102] Notably, the study found that many adolescents' access to contraception rapidly decreased at two months postpartum due to the ending of Medicaid coverage 60 days post-delivery. One of the effects of Medicaid loss was the inability to continue service with the same provider. [103] In this regard, changes in adolescent's insurance coverage interrupted their continuity of care as well as their ability to pay for contraception. In this same vein, adolescent participants in the afore-mentioned Coles et al. study cited issues with Medicaid coverage as a barrier to obtaining contraception.[104] The study also found that barriers to obtaining contraception amounted to more than two times greater risk of unintended birth, particularly for the older teens in the sample. These findings were racially stratified as well, where Black adolescents experienced a greater than sevenfold risk of unintended birth as a result of these difficulties.[105]

A study published in 2017 further investigated the role of cost barriers by implementing an intervention known as the Contraceptive CHOICE Project for teens (n=1371) in St. Louis, Missouri. [106] The intervention included education about LARCs and no-cost provision of the patient's preferred contraceptive method. The study's findings indicate that the removal of barriers to cost, access, and knowledge of contraception reduce overall rates of unintended pregnancy and effectively eliminate racial disparities in unintended pregnancy between Black and White adolescents aged 15-19.[107] In this regard, the no-cost provision of contraceptive counseling and preferred contraceptive method reduced the risk of teen pregnancy.

Family Barriers

Parental Involvement, Privacy and Confidentiality

In this review, issues surrounding privacy and confidentiality were particularly salient. Female adolescents in a 2017 study by Galloway et al. reported mistrust of their providers in maintaining their privacy and confidentiality. When asked about how clinics could improve the comfort level of adolescent patients, these participants again cited privacy and teen-friendly clinical staff as two primary features.[108] Adolescents often experience access barriers as a result of parental involvement in their contraception decision-making, whether state-mandated or not. In focus groups with 15 low-income African-American adolescents in Chicago, participants reported various concerns about personal privacy and confidentiality surrounding hormonal contraception services.[109] These adolescents expressed fear that healthcare providers might report their sexual activity and use of contraception with their parents. This perceived lack of privacy was cited as a reason for why adolescents may be deterred from accessing contraceptive services.

In their sample of female patients at a New York City hospital (n=63), Clare et al. found that nearly 48% of patients aged 16-18 reported concern about parental discovery of contraceptive habits.[110] Another study reported that confidentiality concerns were found to be associated with reduced likelihood of having received contraceptive services among sexually experiences girls and women.[111] These findings were reinforced in a 2018 study using data from the National Survey of Family Growth (n=2,291) which found that 18% of participants aged 15-17 said "yes" when asked if they would ever miss a sexual or reproductive health care visit because their parents might find out.[112] One study suggested that the location of clinics and type of providers used by adolescents has an effect on confidentiality concerns. Chernick et al. found that female adolescents (n=14) at an urban emergency department feared a loss of anonymity when using family providers instead of using school-based health centers.[113] Furthermore, the adolescent participants in this study reported that they intentionally sought out less conspicuous methods in order to avoid attention from their mothers.[114]

These confidentiality concerns have measurable effects. In their 2010 study using the National Longitudinal Study of Adolescent Health (Add Health) data, Ford and Forthofer found that the more adolescents perceived maternal disapproval of their sexual activity or contraceptive use, the less likely they were to have received contraceptive services.[115] Some studies have explored the role of state policies governing parental involvement in contraceptive care. Hopkins et al. found that the need for parental consent in Texas presented an additional barrier to adolescents' receiving care at family planning clinics.[116]

V. Discussion

Overall, the findings from this review underscore the ways in which access barriers contribute to adverse health outcomes such as unintended pregnancy and even rapid repeat teen pregnancy for adolescent mothers. Several key barriers stand out as areas for possible improvement and intervention. For instance, the abrupt loss of postpartum Medicaid coverage experienced by adolescent and adult patients alike.[117] Here, patients face financial challenges not only to accessing contraceptive services just a couple of months following delivery, but also to maintaining continuity of care with their provider. Extending this period of Medicaid coverage for new parents or instituting a system for these patients to obtain transitional coverage would likely eliminate or reduce these adverse effects.

Furthermore, many of the studies examined in this review underscore the inability of many adolescent patients to qualify for or afford contraception. The findings from the Contraceptive CHOICE Project indicate that financial barriers play a pivotal role in rates of unintended pregnancy as well as some of the racial disparities in these rates.[118] In this regard, access to a more robust family planning program at the state and federal levels, such as through Title X programming, may be central to adolescents ability to access these services. Another key finding from this review is the importance of confidential services for adolescents wishing to obtain contraception. For instance, studies indicated that concerns about privacy among adolescents were associated with lower rates of receiving contraceptive services. [119] The salience of confidentiality concerns in qualitative studies with adolescent participants suggest that many adolescent patients may experience family barriers to receiving these services. Since many state policies govern confidentiality and mandate parental involvement in adolescents' healthcare, it is important to examine the intersection of health policy and health outcomes in this context.

On this note, there was a dearth of research on state policy as a barrier to adolescent access to contraception. Very few studies examined school-based health centers and Title X clinics or how different types of clinical settings fulfill contraceptive need among adolescents. Interestingly enough, of the few studies that examined access barriers at the state level, many of these studies focused on Texas. Together, four studies from this review all pointed to access barriers manifesting at the state level as a result of the unique geographical, political, and social environment of Texas. For example, the Hopkins et al. study found that overall adolescents in Texas experience difficulties accessing government-supported family planning services in Texas.[120] Moreover, this study's findings pointed to state parental consent laws as another access barrier. In the Hallum-Montes et al. study, staff of health centers in southern states such as Texas reported discomfort addressing adolescent reproductive health needs, in part due to religious beliefs.[121] Similarly, Vaaler et al. also discovered geographical disparities between provider attitudes and training among urban and rural providers in Texas.[122] In addition, the 2015 White et al. study reported on the impacts of 2011 state legislation on Texas' family planning program, including clinic closures, reduced hours, and funding cuts.[123]

These studies indicate the prevalence of access barriers facing adolescents in Texas. At the same time, a key gap identified in my review is a lack of insight from the perspectives of both healthcare providers and adolescents who face the consequences of these barriers. To further explore the role these barriers play in Texas, I developed a qualitative study of healthcare providers who serve adolescents on a daily basis. Using in-depth interviews, the goal of this aspect of my research is to elucidate providers' experiences providing contraceptive services to adolescents in Texas, their perspectives on Title X programming, and the impact of recent policy changes on their practice.

SECTION THREE:
EXPERIENCES OF HEALTHCARE PROVIDERS

Purpose

After conducting a systematic review of existing literature on this topic, it was clear that there are several unanswered questions about contraception service delivery for adolescents in Texas. In this regard, my research led me to the realization that the collection of qualitative data from providers themselves may provide some valuable insight. In order to collect such data, I conducted semi-structured interviews with healthcare providers who serve adolescents in Texas. Through this portion of my thesis, my goal is to better understand the accessibility of contraception for Texas teens, determine which barriers and facilitators seem to predominately drive this accessibility, and examine how healthcare providers navigate these barriers for their patients.

Methods & Interview Protocol

Semi-structured interviews were conducted with 8 participants at the location of their choice. Approval for human subjects research was obtained from the University of Texas at Austin Institutional Review Board (Study Number 2018-02-0120). Prior to interviewing, a signed form indicating informed consent was obtained from each participant. Participants were recruited via email invitation and interviewed between July and September 2018. Eligibility criteria for participation required that each participant be a health care provider delivering services to adolescents that pertain to contraceptives, such as health education, consultation, or prescription. The final sample of study participants (n=8) were from the Houston and Austin areas. Each provider was assigned a pseudonym as illustrated in Table 1.

Table 1. Providers' pseudonyms, profession, and clinical setting.

Julie	Obstetrician-gynecologist at a Title X clinic
Mary	Obstetrician-gynecologist at a Catholic setting and at a Title X clinic
Kristen	Adolescent health advocate at a Title X clinic
Barbara	Adolescent subspecialist at a Catholic setting
Diana	Obstetrician-gynecologist at a private practice
Amelia	Obstetrician-gynecologist at multiple sites, including a Title X clinic
Rachel	Obstetrician-gynecologist, adolescent subspecialist at a Catholic setting
Hannah	Pediatrician at multiple sites, including a county clinic

The interview focused on topics such as state-specific challenges to serving the adolescent population, recent changes relating to adolescent sexual and reproductive health, and how these changes impact provision of care. In addition, interviews examined the perceived role of community partnerships and advocacy organizations in fostering accessible contraceptive care for adolescents. See Appendix 1B for the interview guide. In an effort to prioritize confidentiality, no demographic information was collected other than the participant's occupation and clinical setting. Interviews were recorded using a digital audio recorder and transcribed by the interviewer. The transcripts and audio recordings were uploaded to Dedoose (version 8.0.44), a qualitative data management program.

The first step of data analysis consisted of identifying themes and subthemes related to the participants' experiences serving adolescents. After transcribing the interviews, I first explored prominent patterns in the excerpts and created a preliminary codebook based on a thematic content analysis approach.[124] After an iterative analytic process, with several rounds of revisions and modifications in response to the emergence of new themes and concepts, a final

codebook was then developed and applied to the dataset. Preliminary themes included: structural factors, patient-level factors, confidentiality, the miseducation of Texas, roles of a provider, and Title X. These themes along with additional sub-themes and patterns are described in further detail in the table below.

Table 2. Themes and descriptions taken from qualitative codebook.

Insurance Coverage	Participants discussed the role of insurance coverage and plans (such as CHIP, Medicaid) in contraceptive service delivery.
Reimbursement and Stocking	Participants discussed how reimbursement procedures and the financial ability to stock certain contraceptive methods influences the provision of contraception.
Catholic Restrictions	Participants discussed the effects of Catholic Ethical and Religious Directives on contraceptive counseling and interactions with patients.
Confidentiality/Privacy	Participants discussed navigating confidentiality and privacy concerns with adolescent patients and their families.
Managing Patient Expectations	Participants discussed how they navigate patients' expectations about contraception, pregnancy, and sexuality.
Miseducation of Texas	Participant discussed state policies surrounding sexuality education for adolescents and how the effects of these policies enter into their practice.
Title X Program	Participants discussed the Title X program, including perceived benefits for patients and the anticipated consequences of proposed policy changes.
Prenatal/Postpartum Contraceptive Care	Participants discussed contraceptive planning for pregnant patients and the provision of contraception in the postpartum period.

Results and Discussion

Several key themes arose from the data. Many providers described having to navigate health systems barriers as well as financial barriers in their practice. Furthermore, participants described cognitive challenges to serving the adolescent population of patients in particular and the unique barriers that arise during pregnancy and the postpartum provision of contraception. In addition to describing how they navigate clinical care on a day-to-day basis, providers discussed broader themes such as the miseducation of Texas as a whole and the various roles of a provider. Finally, providers expressed their reaction to proposed changes to the Title X program.

Structural Barriers: Health Systems and Financial Concerns

Many participants in this sample worked in Catholic-affiliated institutions. In this regard, there were frequent discussions of the Catholic institution's opposition to the provision of contraception for the sake of family planning and the ways in which this policy impacted their provision of care. Some providers discussed the unique barriers present in a Catholic system with regard to the postpartum provision of contraception. For instance, Mary discussed how the Ethical and Religious Directives[125] in place at Catholic health systems prevent new mothers from accessing contraception immediately following delivery:

> *"[B]ecause we are in a Catholic institution, it also presents a hurdle. So we can't give them contraception while they are in the hospital, which is what we would do in other places. Instead, we counsel them for what kind of contraception they would like to use when they go back for their postpartum visit 2 to 6 weeks later depending on the clinical site. And so I'm not necessarily seeing them at that clinical site. But I make sure that they have a plan for what they desire. So that doesn't impede my counseling in any way, but it will later potentially impede their ability to get contraception depending on what their clinic is."*

In this regard, providers like Mary who work in Catholic-affiliated settings are able to provide contraceptive counseling but not the actual contraceptive methods at their site. Mary also described the ways in which her practice has been modified in order to accommodate structural barriers put in place by both the Catholic system and Medicaid program:

> *"One of the reasons that we make sure that at least on two occasions during their prenatal care that we're talking to them about contraception is because that we want to give them the opportunity to choose sterilization if that's something that they're interested*

in. And what we actually do is that we have a delivery service also at [a hospital][‡], which is Episcopalian and not Catholic…And in order to get Medicaid to paperwork done, that Medicaid paperwork must be signed between 30 and 180 days before the planned sterilization procedure so it's got to be dealt with before 36 weeks. So it's--we have sort of time-bound issues with sterilization consent as well. So we try really hard to make sure that that's addressed early and often during prenatal care."

Other providers echoed this sentiment, describing alternative pathways for patients to still obtain their preferred contraceptive method (sterilization in this case) despite the institutional restrictions in place by both the hospital and the insurance provider. In this same vein, some participants described difficulties developing a contraceptive plan prior to delivery for pregnant patients due to the time constraints of Medicaid coverage.

"One thing that's not great is that [Medicaid] typically ends six weeks after the baby's born, so six weeks postpartum. And it stops--it doesn't cover much. It depends on the plan, but most plans don't cover much for the mother...And then people wonder why we have the highest rate of rapid repeat teen pregnancy"

-Kristen, a provider at a Title X clinic

Barbara, another participant who works in specialty care for adolescents at a Catholic setting, discussed how this system can often restrict the types of reproductive health services offered to patients:

"It's not my idea of what is comprehensive family planning for teenagers. So I don't, by choice, I don't do primary care within the Catholic hospital. I think that it is very difficult, and it's a huge barrier across the country are Catholic hospitals--I think a fifth

[‡] The name of this hospital has been redacted to maintain confidentiality.

> *of hospitals are Catholic. And so if they're serving teenagers—well, at any age—people don't have access to adequate reproductive health."*

Notably, it was not exclusively providers who work in Catholic systems that commented on these restrictions. Kristen, who serves at a Title X clinic, remarked *"they don't do LARC insertion and they don't do BTL. So yeah. We don't really--We don't mess with [the Catholic institution]. For that reason."* In this way, Kristen directs pregnant adolescent patients to another hospital for labor and delivery in order for them to be able to access the full range of contraceptive options, like the bilateral tubal ligation (BTL) sterilization procedure.

In this same vein, many providers pointed out that access to contraceptive services ultimately depends on both the clinical setting and the funding stream. For example, Barbara described how institutional policies can have broad impacts on what contraceptive methods she is able to offer to patients. She explained:

> *"So if you are operating in a Catholic institution you would never be able to offer a copper IUD as an option for birth control. On the other hand, if you're operating in a non-Catholic setting serving Medicaid patients but you're not a Title X clinic, you can't -- or CHIP I should say-- you can't offer LARCs often because they're not covered…So there are pharmacies that you can get birth control pills, 3 months for $20…But that's a method that is--especially in teenagers--not, is not reliable. We know that teenagers don't stay with it, and so in my mind, less than ideal. But it's something. So you do have a little bit of option, but really it's very limited. Very limited. And Texas really makes these things difficult."*

Here, Barbara references the statewide policies that govern CHIP. These policies dictate that the program only cover contraception as treatment for a patient's medical condition, such as for

heavy bleeding or polycystic ovarian syndrome. In this case, providers would apply a medical code and need to obtain authorization for coverage. Barbara explained:

> *"CHIP Medicaid policies do not--they have exclusions for birth control, which you probably know. If you are under the age of 18 and you have CHIP, there are exclusions in most of the plans that say it is not--you cannot use that to cover contraception. Now, if there's a medical indication, I can get it covered under a medical indication but purely to prevent pregnancy it is not covered."*

In addition to restrictions on contraceptive coverage by state-run programs like CHIP, Rachel also pointed out that *"In Texas as a minor, unless you are under Title X funds, you have to have parental consent for contraception. So a teen that does not want their parent to know that they are taking contraception is gonna have a problem with having to find a place that's a Title X clinic of which there are not very many in Austin."* Here, Rachel touches on the fact that a majority of patients, with the exception of those adolescents covered by federal Medicaid (not CHIP) and those seeking care at Title X clinics, must involve their parents in the contraceptive decision-making process. Rachel, along with several other participants, also commented on the fact that often adolescent patients who need to access services confidentially face difficulties. In these discussions, a couple of participants described the relative lack of clinics in large stretches of Texas. Barbara reiterated that *"if you look at Title X funded clinics across the state of Texas there's the clusters of them but you have entire stretches of the state--I'm just thinking about the border where there's nothing…it is so sub-optimal."* These comments suggest that the geographical landscape of Texas, along with its shortage of clinics, may contribute to the inaccessibility of reproductive healthcare for adolescents.

Confidentiality & Consent

Several providers considered the ways in which state-mandated parental involvement in adolescent healthcare poses a barrier in the realm of sexual and reproductive health. For instance, Mary explained that *"with adolescents the issue is that any time that you create a barrier, any time they have to go to a parent in order to seek healthcare, it just decreases their health-seeking behaviors…I think that it's pretty clear that that leads to decreased rates of using contraception and decreased rates of being able to feel confident seeking services to prevent or treat sexually transmitted infections."* While most providers discussed how they strive to involve parents in discussions with their adolescent patients when possible, they also discussed the importance of having a portion of the visit private so that adolescent patients are able to ask and answer questions more openly. For example, Hannah explained *"you hear about somebody going to the doctor and not getting a confidential interview when they're 15 or 16 or 17. And it just breaks my heart because I know that that teen might have had at least one question that they wanted to ask not in front of their parent."* She went on to explain that *"it's not my place to keep secrets, but it is my place to take the best medical care of a kid. And if the child is having sex, and doesn't want their parent to know because they're going to get beat up or thrown out of the house, it's not medically correct for me to rat them out to their parent."*

Likewise, providers discussed how they approach the issue of confidentiality in their practice. One provider, Diana, said that she integrates a conversation about the limitations of confidentiality at the beginning of each session. She explained *"In general, their parents--you know if they use their parents' insurance--their parents are going to get the EOBs. I mean so it's going to say 'Annual Exam' or 'STI Screening.' That kind of thing. So if they don't want their parents to know what they're doing in the office, they need to be really upfront with me. And I*

have to tell them that there are certain obligations I have." Diana also mentioned how she communicates with the parents of adolescent patients: *"I say 'Okay. For the first part of the interview, I'm happy for you to be here. But then for the last part, usually I like to do that by myself with your daughter. And they're like 'Okay, cool. Whatever.' And they walk out."* In this regard, while the state of Texas mandates parental consent in order to obtain contraception, some providers find a workaround to adhere to this policy while still effectively communicating about sexual health with their adolescent patients.

Title X

All participants were asked about the Trump administration's recently proposed changes to the Title X program. These changes may limit what methods are prioritized, how methods are discussed, and the ability for clinics to guarantee confidentiality to minors.[126] While all providers opposed the changes, some participants cited different reasons for their opposition. Julie, who works in a Title X setting, explained:

> *"Yeah, I think anytime we talk about limiting Title X funding or switching who it's provided by and with that switch implementing new restrictions, I think there's a lot of concern felt amongst us as providers and I think the patient population as well that we're just putting up more barriers to adolescents receiving the birth control choice that they want, and will be directly tied to teen pregnancy rates going up."*

Kristen, another provider working at a Title X clinic, echoed this sentiment:

> *"[I]t cannot be overemphasized the importance of offering confidential health services to adolescents. Not only because sometimes their safety is involved, their housing--they might get kicked out of the house if their parent finds out they're pregnant or they're*

sexually active--but also because if they don't know that they can get the services confidentially, they won't come. They won't come, and they won't get the services."

In this regard, providers often mentioned the importance of having confidentiality as an option for adolescents whose privacy and safety concerns might override their concern for their own sexual and reproductive health. Other providers were wary of new changes to the Title X program because of their past experiences with Texas state policies. Mary noted that:

"*what we've seen is that any time you change around eligibility for what clinics can provide care with the funding source…we did this in Texas back in 2011, and when you change who can get funding, what you end up doing is shutting down huge swaths of clinics that serve huge portions of the underserved population. And so while you may only shut down 10% of the state, what you may end up doing is shutting down all of the clinics in a given area…women who live in more sparsely populated areas, more rural areas, can actually be sort of stranded without healthcare. So I find that to be a big problem."*

Barbara cited the anticipated administrative burden on providers in her opposition to the proposed changes. She explained *"If you're providing care, you can't also be providing paperwork…So if they're rewriting all the Title X stuff, my biggest fear is that the burden, the administrative burden of having Title X funding is going to outweigh a place's availability to provide the care."*

Providers frequently mentioned the benefits of Title X programming in interviews. For example, Rachel mentioned "*when I was working at a FQHC and we had Title X funds and we also had a class D pharmacy on site, it was a lot easier to just go ahead and see a patient and provide a contraceptive method regardless of what it was. Because whether or not the patient*

was funded, it was going to get paid for somehow." The reliability of the federal Title X funding stream played out in other ways as well. Rachel continued on to say that stocking the more expensive (and highly effective) long-acting reversible contraceptive methods for adolescent patients was never an issue in the Title X setting. Rachel said:

> "*We had a bunch of Mirenas and a bunch of Nexplanons there already. If you're in a private clinic, those devices are expensive."* In her interview, Rachel drew from her past experiences working in a variety of different settings as a provider. She noted that at one clinical setting "*when I wanted to place a device, I had to end the visit. The patient went home…I was not allowed to place the device at the same time as the initial visit. Which is--it is an access issue because there's a lot of people who come once and never come again. And those people are obviously at higher risk for pregnancy if they don't get the device at the time that you counsel them."*

This notion of attrition as a result of reimbursement came up in a couple of other interviews as well. Many providers emphasized the importance of same-day provision of care in terms of ensuring that patients are able to access their preferred contraceptive method.

In fact, while the providers who serve adolescents in a Title X context did not cite any barriers due to stocking or reimbursement for contraceptive methods at their clinic, they did cite issues with immediate postpartum (IPP) provision of contraception in hospitals. Julie mentioned:

> *"For a postpartum LARC placement we don't have a way that we can put Nexplanons in the hospital, in the patients immediately postpartum. And so they have to come back for a visit at the clinic to get that placed. And so that's kind of unfortunate, that's kind of a barrier we're trying to address."*

Additionally, providers who worked in non-Title X clinical settings pointed out the expenses associated with certain contraceptive devices. Amelia explained:

> *The other thing that has been a barrier to IPP LARC, not specifically for adolescents but for--this is across the board--has been that typically the reimbursement from the state to the hospitals hasn't covered the entire cost of the device, so hospitals don't want to stock the device which is relatively expensive, only to eat the cost differential for that.*

Thus, health systems barriers at the hospital level prevent patients from accessing IUDs and implants immediately postpartum. In this regard, reimbursement procedures and the financial ability to stock certain contraceptive methods varied by clinical settings in ways that directly influenced the provision of contraception.

Managing Patient Expectations

While providers mostly discussed the role of financial and structural barriers in their practice, they also described the ways in which they manage expectations with their adolescent patients, particularly with regards to side effects. Barbara explained *"[S]pending the time to do the anticipatory guidance at the beginning, really explaining 'If you are nauseous within the first two weeks of taking birth control pills, that's actually kind of what I expect, but it gets better.' Otherwise, they're calling, they're stopping their pills…Okay so if you don't prepare teenagers that that is going to happen, they are going to be calling every day.*" Another provider discussed how she uses a reproductive life plan with adolescents. Amelia explained:

> *"I think actually having a conversation with a teen in general that their reproduction and therefore their contraception is brought into the conversation about what they want to do and what they want to be with their life. I almost think every adolescent could benefit*

from something like that early on…to have the opportunity to think through what their reproductive life plan is"

Providers also mentioned how important it is to address adolescents' preconceptions about certain contraceptive methods or parts of the exam. Kristen described *"A lot of young women who have never had a pelvic exam or a pap smear before are really freaked out."* Likewise, Julie explained that after inserting an IUD or Nexplanon "*we'll see people back a few weeks later saying I'm still bleeding, I'm still spotting and we'll have to remind them that that's totally normal. That's to be expected.*" Another salient theme in the interviews was the notion that adolescents actually self-select for different methods. For instance, Hannah explained that *"if they don't want their parent to know, I need them to have a place where they can keep the pills that going to be accessible to them without their parent finding it or being aware of it. And so a lot of times the pill is out just because of that whole confidentiality part."* For adolescents, it seems that the ideal method of contraception can vary based not only on medical indications, but also on family considerations.

The Miseducation of Texas

Although participants were not explicitly asked about sexual health education in Texas, many commented on the lack of comprehensive programs in Texas schools. Kristen remarked, *"In Texas, we have a lot of organizations that unfortunately spend a considerable amount of time and resources miseducating people. And we don't have a standard curriculum in public schools as I'm sure you're also aware."* She went on to say, *"Our state has a real problem with providing basic information and education that is factual and is unbiased. About sex, about sexuality, about pregnancy, about abortion, about birth control."*

Other providers also pointed to a lack of sexuality education as a major hurdle for adolescent patients. Mary said *"Well, I think one of the big challenges that I see here as well is that our education, our sex ed is so disparate here in Texas. Because there's been a lot of funding and interest directed towards abstinence-only education…What would be wonderful as a physician is if I were reinforcing something that was a factual educational piece that all kids had growing up as opposed to potentially deviating from cultural norms."* Mary, along with other providers, remarked on the difficulties that providers face when trying to fulfill the role of health educator along with their other duties as a provider. Diana also commented on the education piece. She noted *"Well, you know a lot of education is abstinence-based education that's supported by our legislature…They have a lot of misinformation. Our state seems to think that not using evidence-based medicine is the way to go."* In this way, many providers brought up the ways in which state policies that restrict sexual health topics in public school may harm adolescent patients searching for medically accurate information.

Final Thoughts

Findings from this qualitative sample suggest several different ways that access barriers affect adolescents in the context of contraceptive care. Importantly, the family barriers that were identified in the systematic review are also acknowledged by Texas providers who work with adolescents as relevant. While some adolescent patients are comfortable enough to have conversations about sexual health with their parents in the room, many others require some portion of the visit to be private in order to have honest conversations with providers about their sexual health needs. As discussed in the systematic review, many adolescent patients go into appointments with providers distrustful of their ability to obtain confidential or private care.[127]

Thus, establishing trust in the patient-provider relationship with adolescents requires open communication about privacy needs and a prioritization of confidentiality in care.

Moreover, providers discussed how certain structural barriers at the health systems level appear in context. Primarily, interviewers mentioned the role of Catholic and state policies in restricting funding and availability of contraceptive methods. This data coincides with growing numbers of religiously-based restrictions on sexual and reproductive health services in hospitals throughout the U.S.[128] A 2016 report by the American Civil Liberties Union (ACLU) found that approximately 1 in 6 hospital beds belong to a Catholic hospital in America.[129] While some studies explored in the systematic review pinpointed the ways in which insurance coverage and funding streams can influence access, these interviews further illustrate how some of the mechanisms for payment and stocking are flawed.

For instance, the qualitative data collected in this thesis support the findings from existing literature on postpartum contraceptive use. There seems to be a lack of funding in place for hospitals to provide IPP LARC to new adolescent mothers, where in the qualitative study sample Amelia pointed to the lack of funding mechanism for this IPP service as a major issue. Likewise, a study conducted by the Texas Policy Evaluation Project demonstrated the lack of access to sterilization and LARC methods for postpartum women in El Paso and Austin, Texas. In this study, findings suggest that more advantaged groups (in terms of measures such as insurance coverage and income level) were more likely to obtain their contraceptive method of choice at 6 months following delivery.[130] One of these barriers was the absence of IPP provision of IUDs and implants in hospitals.[131] A cohort study of postpartum women in Austin, Texas also found that two-thirds faced an access barrier to their preferred contraceptive method.[132] While young women and adolescent minors face distinct challenges to accessing affordable and effective

contraceptive methods, I must stress that these two demographic groups have many access barriers in common in Texas. In this regard, there seems to be similarities between the barriers most cited by Texas patients (both for adolescents and adults) and their providers.

In addition to barriers to IPP LARC provision, providers commonly cited the fact that state-funded Medicaid restricts coverage for family planning and contraceptive services. In another study, with a sample of publicly insured women in Texas, researchers found associations between provider- and health systems-level barriers and participant's ability to obtain preferred methods such as LARCs and permanent contraception.[133] Such access barriers amounted to a risk of pregnancy that was at least three times greater for these women.[134] These systemic barriers must be addressed in order to improve contraceptive service delivery in Texas.

Given that Texas has opted out to expanding the Medicaid program, it may not be surprising that 29% of uninsured adults in the coverage gap nationally reside in Texas.[135] Research has indicated that increasing parent coverage correlates with higher enrollment of eligible children in programs like Medicaid and CHIP.[136] In the context of Texas, where clinic availability and insurance coverage are already heightened issues, it is vital to address these roadblocks and counter them with strategies such as anticipatory contraceptive planning and sexuality education with teens. Overall, while this qualitative data is not representative of providers in Texas and should not be generalized to a larger population, the findings do provide important experience-based insights for policy, programs, and potential interventions to improve access to contraception for adolescents.

SECTION FOUR:
STATE POLICY ANALYSIS AND PROPOSAL

Overview

In this final section, I discuss the advantage of modifying existing state policies regarding family planning. First and foremost, I must reflect on the status of Texas family planning infrastructure and consider the financial burden and benefit of family planning programs. Texas Health and Human Services continues to operate the Healthy Texas Women program, providing no-cost family planning services to those who fit the eligibility criteria. As mentioned in Section One, some adolescents aged 15-18 are eligible for this program but must have their parents apply for enrollment on their behalf. Moreover, the program has income requirements of no more than 200% of the federal poverty level.[137] Public funds for services in Texas also use a tiered system that deprioritizes the distribution of funds to private reproductive-health focused providers.[138]

In addition to the state-run family planning program, there are a network of Title X clinics that serve adolescents. As the sole Title X grantee for the state of Texas since 2013, the Women's Health and Family Planning Association of Texas (WHFPT) allocates funding to clinics throughout the state. According to the 2016-2017 annual report by WHFPT, each dollar of funding for Title X programs in Texas yields a $7.47 return.[139] Despite these returns, the amount of federal Title X funding received by Texas decreased by $1.8 million between 2010 and 2016, meaning a substantial decrease (38%) in the number of patients served.[140] As of September 2018, there are only 94 Title X clinics open.[141] Compared to states like California and Florida, which have 375 and 157 Title X clinics respectively,[142,143] access to Title X in Texas leaves much to be desired.

The need for more publicly funded clinics in Texas has tangible health outcomes. According to the Texas Youth Risk Behavior Survey data from 2017, 45.3% of adolescents aged 16-17 years reported ever having had sexual intercourse; however, only 19.2% of adolescents within this age group used contraceptive methods such as birth control pills, IUD, implant, shot, patch or ring to prevent pregnancy before last sexual intercourse.[144] Moreover, the teen birth rate in Texas ties for fourth highest nationally with 34.6 births per 1,000 females aged 15-19.[145] Considering unintended teen pregnancy as an issue of injustice and inequality, the state of Texas must invest in increased reproductive health care access for adolescents at-risk for unintended pregnancy.

Ethical Considerations

There has been substantial scholarship on the historical injustices of family planning programs. While some of the more nuanced ethical dilemmas of pregnancy prevention fall outside the scope of this thesis, I want to briefly acknowledge this history. Family planning and the politics of reproduction in the United States has often reflected systemic issues of racism and sexism through forced sterilizations,[146] the problematization of teen motherhood,[147] and even the foundation of gynecology by J. Marion Sims.[148] In making a policy proposal that seeks to fulfill unmet contraceptive need for adolescents in Texas, I feel it is important to ensure that state-funded family planning initiatives are ethically responsible and ensure the provision of these services is free from coercion.

Access to contraception for adolescents should be regarded as a pathway toward reproductive autonomy and justice, not simply as a way to lower public cost and certainly not to prevent specific demographics of people from bearing children. While the following policy

proposal advocates for increased funding and support to Title X programming and the low or no-cost provision of LARCs, providers must be made aware of the issues associated with targeting statistically "high risk" patients for LARC use without adequately reflecting on each patient's preferences.[§] The framing of teen pregnancy as an inherently problematic occurrence excludes minors from the framework of reproductive autonomy. In addition, the stigmatization and oppression of sexuality and parenthood in young people is often classed, raced, and gendered.[149] Some adolescents intend to become pregnant, and these intentions should be considered and respected as valid. In particular, patient-provider communication should comprise of open and nonjudgmental counseling that affirms the right of the adolescent to make his or her own informed decisions.

Socioeconomic and Health Disparities

There are several disparities related to teen pregnancy, birth, and parenthood, particularly for adolescents in Texas. Teen pregnancy is associated with an increased risk for adverse birth outcomes such as pre-term delivery, low birth weight, and neonatal mortality even controlling for major confounding variables like race, education level, and utilization of prenatal care.[150] Given that rates of unintended pregnancy and birth among minority women are more than twice that of their white counterparts,[151] unintended teen pregnancy is also racially stratified. Moreover, a report in 2018 revealed that Texas teens in foster care are at a disproportional risk of pregnancy, where 5.7% of girls aged 13-17 in foster care were pregnant in 2015 compared with

[§] For further discussion on reproductive oppression and the ethical implications of contraception promotion, see Gomez, A. M., Fuentes, L., & Allina, A. (2014). Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspectives on sexual and reproductive health*, *46*(3), 171-175.

only 1.2% of their peers.[152] Also, in Texas about 1 in 5 of births to teen mothers are repeat teen births.[153] In this regard, there are significant disparities in the level of pregnancy risk for adolescents depending on their social location.

The educational outcomes of teen mothers further demonstrate the ways in which unintended pregnancy is an issue of social justice for this age group. Teen pregnancy and parenthood is responsible for 30% of adolescent females who failed to finish high school.[154] In fact, half of teen mothers had yet to receive a high school diploma at age 22.[155] Educational attainment disparities between teen mothers and their peers can also result in restricted job opportunities that contribute to poverty. For these reasons, initiatives that reduce unintended teen pregnancy can prevent adverse outcomes for both the infant and parents.

Overview of Proposed Policy Changes

This thesis has illustrated the prominent access barriers to contraception at both the state and national levels. During the upcoming spring 2019 legislative session and in sessions in the future, it is my hope that Texas state legislators enact health policy changes favorable for the millions of Texans, particularly adolescents, seeking contraceptive services. From this systematic review and qualitative analysis, my recommendation for health policy moving forward includes five key strategies: (1) prioritize confidentiality for adolescents seeking contraceptive services; (2) develop a LARC initiative modeled after similar programs in Colorado and Iowa, one which also addresses the need for IPP implementation; (3) support the provision of contraceptive services and sexual health education in school-based health centers across the state; (4) expand Medicaid eligibility and funding for family planning programs; and (5) create a standardized notification and referral system for patients in Catholic settings. Each of these policy proposals are developed further below.

(1) Prioritizing Confidentiality

There is an abundance of evidence that suggests that Texas policies on adolescent confidentiality and mandatory parental notification are harmful for minors. As discussed at length in previous sections, access to confidential services for adolescents is vital. While ideally adolescent patients will be able to involve their parents and families in medical decisions and have candid discussions with them about sexual health topics, not all adolescents are capable of doing so. In order to foster access to confidential services for adolescents, increased state and federal support of Title X programming is necessary. In a nationally representative study of adolescents (n=504), nearly half of participants felt that the presence of parents at consultations influenced the conversation.[156] Moreover, the qualitative data from this thesis indicate that providers seek to prioritize confidentiality in visits regardless of state policies. For adolescents in situations where involving their parents could be harmful, state-mandated parental consent laws result in reduced healthcare utilization.

Other states (in addition to federal programs such as Title X) acknowledge the need for confidential sexual and reproductive healthcare for adolescents. Currently, Texas allows for minors to consent to only some contraceptive services alone, and permits physicians to contact the minor's parents about utilization of STI services or prenatal care.[157] Furthermore, only two states (Texas and Utah) explicitly denounce the use of state funds for confidential contraceptive services to minors.[158] Texas legislators should not only increase support for Title X programming throughout the state, but also ensure that all minors who need confidential care have an accessible clinic to visit.

(2) The Texas LARC Initiative

There is a growing body of literature on the importance of offering low or no-cost long-acting reversible methods. Particularly for adolescents, LARCs are safe and effective ways to prevent unintended pregnancy. For LARC methods, adolescent continuation at one-year post-implantation was right at 81% whereas non-LARC methods yield a continuation rate of only 44%.[159] The ability to insert these methods without upkeep is one of the reasons they are highly effective; the one-time placement of intrauterine devices (IUDs) and implants such as Nexplanon limits user error. Contraceptive counseling and the promotion of LARCs methods considerably reduce unintended pregnancy among adolescents. Furthermore, LARC methods are highly effective and safe for all ages of childbearing women.[160] Adolescent females also have demonstrably higher rates of continuation with LARC methods in comparison with shorter-acting alternatives.[161] Reducing access barriers to LARC methods should be a top priority for Texas in light of adolescent health indicators. I suggest that Texas develop its own LARC initiative. Based on the success and effectiveness of LARC methods, coupled with the findings from this thesis, I propose that the Texas Department of State Health Services (DSHS) amplify its provision of long-acting reversible contraceptive methods (LARCs) to adolescents ages 15-19 at low or no-cost, with special attention paid to IPP LARC.

Introducing more funding streams for programs that provide LARC methods to adolescents would likely improve the ability of adolescent patients to avoid unintended pregnancy. States such as Colorado, Oklahoma, Iowa, and New Mexico have implemented similar initiatives with substantial success.[162] For example, the Colorado Family Planning Initiative to provide no-cost LARCs to women lowered birth and abortion rates by nearly 50% among adolescents. [163] Ultimately, the program averted more than $55 million in public

assistance costs.[164] In addition, the privately-funded Iowa Initiative boosted funding for Title X clinics in order to increase the use of LARC. This initiative was successful in the use of IUDs and implants increased by 218% and 829% respectively, coupled with a 5% decrease in unintended pregnancy rates in 3 years.[165] Analysis of the cost savings for adolescent women found that every dollar spent in the program yielded a $17.23 return.[166]

Given that there are other issues with hospital and clinical reimbursement for contraceptive methods that generate hesitation to offer these services, Texas could alleviate some of these challenges by stocking more clinics with these methods at low or no-cost. There is no medical reason that prevents a physician from providing same-day contraception to patients.[167] When providers are forced to act in a way that does not represent the best interest of their patient, these policies may infringe on some of the basic tenets of medical ethics such as representing the patient's best interest. Encouraging same-day provision could be accomplished through incentives that reduce the upfront cost of LARCs for providers.

Additionally, a concrete way to reduce unintended pregnancy for adolescents and for women as a whole is to reduce barriers to IPP implementation of long-acting reversible methods. IPP LARC can effectively address the morbidity associated with rapid repeat pregnancy, in addition to convenience and cost-effectiveness for the patient and provider.

A study published in 2012 found that use of IPP contraceptive implants significantly reduced rapid repeat pregnancy and had high continuation rates for adolescent participants.[168] Given that many postpartum patients prefer these methods yet continue to face access barriers, implementing changes at the health systems level is crucial to alleviating negative health outcomes. One of these afore-mentioned barriers includes the mandatory 30-day waiting period prior to Medicaid coverage of a sterilization procedure.[169] While it is important to ensure that

sterilization procedures are not conducted in a way that is coercive for vulnerable patients, the waiting period introduces significant logistical issues for providers and patients seeking this procedure immediately postpartum. Prenatal contraceptive planning should be a priority for all pregnant adolescent patients so that they are able to maintain control over their reproductive lives and the timing of pregnancies. However, plans for obtaining contraception only goes so far in a system that makes contraceptive services inaccessible.

(3) Contraception and Sexual Health Education in School-Based Health Centers

School-based health centers (SBHCs) are associated with improvements in not only health-related outcomes such as healthcare utilization, but also educational outcomes such as grade point average for the students they serve.[170] While the SBHC started in Dallas, Texas in 1970, today, over 2,000 SBHCs operate in 49 states.[171,172] An increasing percentage of SBHCs are able to dispense contraceptives (including LARCs), but policies at the school district and state level often restrict this ability.[173] Texas law mandates that written parental consent be obtained prior to a student's receipt of services at SBHCs, but specifies that parents can approve ongoing access to services for their students through a one-time consent form.[174] Furthermore, state policy prohibits the provision of reproductive health services, counseling, or referrals with state funds.[175] In Texas, sexual health education programs often exclude information about contraception and school-based health centers are prohibited from on-site distribution of contraception.[176,177]

Adolescents who understand the impacts of teen pregnancy and parenthood will be better equipped to make decisions about their bodies, which could decrease high-risk sexual behaviors and increase use of contraception. In this regard, the current policies concerning sexual health

education should be revised to include more comprehensive topics. Medically accurate, evidence-based sexual health education programs that include information about contraceptive methods could be utilized in school-based health centers (SBHCs) to inform adolescents about their sexual and reproductive health. Moreover, financial support should be made available to SBHC settings to provide contraception to adolescents. SBHCs present a convenient, teen-friendly setting in which adolescents access these services. In order to fully tackle some of the health systems barriers, including logistical challenges for adolescents, Texas must increase its support for SBHCs. Sexually active adolescent females who had access to an SBHC were more likely to use hormonal contraceptive methods and receive pregnancy or disease prevention care.[178]

(4) Medicaid Family Planning Expansion

Without publicly funded family planning programs in Texas, the pregnancy rate for adolescents in the 15-19 age group would increase by an estimated 73%.[179] Even so, publicly funded health centers in Texas meet only a tenth of the need for public family planning.[180] Despite this, Texas sought to exclude Planned Parenthood from its Medicaid program in 2011, which has since resulted in a lengthy history of legislation and adjudication. Recently, the state's attempt to remove the network of providers was overruled by a federal judge in February 2017.[181] As a result of Texas' exclusion of Planned Parenthood and other organizations that affiliate with providers of abortion, the state has foregone federal funds for its family planning program and continues to operate its Healthy Texas Women program with solely state funding. While Texas is currently awaiting approval for its family planning waiver request to reinstate federal funds, it must first fix its discriminatory policy against abortion providers and affiliates.

At the same time, I propose that Texas reinstates federal funding for family planning and prioritizes the health of adolescents by expanding the network of providers instead of excluding them on political ideological grounds.

(5) Catholic Notification and Referral System

With respect for the Ethical and Religious Directives, I recommend that a policy redefine the obligations of Catholic systems to include transparency and referrals. While this recommendation does not mean compelling Catholic institutions to break these directives, it does mean that these institutions and the providers who work within them have a newfound responsibility to address the contraceptive concerns of their patients through a process of full information and continuity of care. In this regard, Catholic hospitals should be required to work with existing networks of providers to ensure that their patients' needs are being met through referral. The development of a comprehensive referral system for patients in Catholic settings would increase the ability of these patients to receive the contraceptive method of their choice.

Furthermore, all patients at Catholic settings, particularly those who plan to deliver at Catholic-affiliated hospitals must be made aware of the restrictions on contraception and other policies that impact sexual and reproductive health services. Transparency should be prioritized in these situations, particularly in light of the qualitative findings from this thesis. Instituting this system would remove some of the hurdles that adolescent patients are required to jump over in order to access contraception. Particularly for pregnant teens, open discussions about their options and the restrictions of Catholic settings should be had prior to delivery so that the option of IPP contraception is available. For instance, due to the mandatory waiting period between Medicaid authorization and a tubal ligation sterilization procedure, patients must be informed

early and often if they wish to be able to undergo this process. Adolescents must already navigate the confounding policies of health systems that restrict insurance coverage and confidentiality. At minimum, they should be informed on whether or not their healthcare provider must prioritize religious policies over the provision of medical care.

Implementation Challenges

In order to implement these policy changes in Texas, there will need to be a shift in state priorities from upholding conservativism and rigid religiosity to supporting more harm reduction and prevention initiatives. Moreover, the Department of State Health Services would need to find a way to subsidize the cost of LARCs and train more healthcare providers in implementation. A potential challenge to these proposed changes is certainly the resistance to public provision of contraceptives among those with religious and ideological objections. Historically, Texas legislators have opposed the public provision of reproductive health services and education to minors, citing the importance of encouraging abstinence.[182] On the other hand, the program's cost-effectiveness and improvements in health outcomes could result in bipartisan agreement. The overwhelming support of physicians for confidential services made available to adolescent patients might also sway legislators. Fundamentally, the increased financial support of family planning infrastructure would demonstrate a commitment to the sexual and reproductive health of Texas teens. Overall, Texas policymakers may find that increasing financial support of family planning clinics offers more benefits than it does burden. Unfortunately, it may take a drastic compositional change in the Texas House and Senate or else a shift in the existing balance of power for many of these benefits to be realized. Given the need for robust family planning and

the potential for these suggested policies to prevent adverse health outcomes, these matters must be addressed with urgency.

CONCLUSION

While this thesis manuscript reveals trends and patterns on a national and statewide scale, further research must be conducted to evaluate several areas of unmet need for adolescent patients. First, Catholic health systems make up a significant portion of hospitals in the U.S., and as a result, it is important to investigate ways in which contraceptive access can be improved through referral systems, preemptive contraceptive planning, and clarifying the limitations on reproductive health in these settings for future patients and providers.

Second, intersectional health systems barriers such as the contraceptive coding dilemma discussed earlier should be addressed by state health policies in order to increase access to these vital services. Particularly for new teen mothers in the vulnerable postpartum period, the ability to access the full range of contraceptive methods on demand is crucial to reduce unwanted teen and rapid repeat teen pregnancies in Texas.

Finally, research into state-level barriers is key to improve adolescent health outcomes. Data from the perspectives of providers and adolescent patients themselves are particularly important to understanding key priorities and to informing the development of interventions to address the barriers they experience.

APPENDICES

Appendix 1A

Systematic Review Search Criteria

Databases:

PubMed, MEDLINE, CINAHL, PsycINFO, SocINDEX, Health Source (Nursing/Academic)

Search Terms:

contracept* OR "birth control" OR “family planning” (in Abstract)

adoles* OR teen* OR minor OR youth OR "high school" (in Abstract)

barrier* OR restrict* OR access* (in ANY field)

sexual health or reproductive health or pregnan* or reproductive care (in ANY field)

Inclusion Criteria:

The papers had to have been published between January 2009 and June 2018, written in the English language, be peer-reviewed academic journal articles, and be full-text papers. Furthermore, the study’s target population must include adolescents aged 13-18. The focus of the study must be contraceptive service delivery and barriers patients face when seeking these services in the United States. The studies cannot solely focus on pregnancy prevention, birth rates, methods of choice, or sexual behaviors. In addition, the study must contain some type of direct patient or provider input, such as from survey data, interviews, focus groups, program or chart reviews. The study cannot be an appraisal of an intervention or commentary on a prospective policy change, unless experiences related to receiving and seeking contraception are included.

Appendix 1B

Interview Protocol

Introduction

- Remember to thank the participant for agreeing to an interview

- Review the purpose of the study:
    - To examine the experiences of healthcare providers in Texas who serve adolescents seeking sexual and reproductive health services.
    - To identify any barriers or unmet needs

- Provide form to obtain consent and explain the methods of maintaining confidentiality

- Remind the participant that they are under no obligation to answer all of the questions and that they can take a break at any time

Experiences Serving Adolescents

- Tell me about the context in which you serve adolescents who seek sexual and reproductive health care.

- To what extent do you see a need to walk patients through contraceptive decision-making? Are the full range of contraceptive options provided to teens? Are any options encouraged or discouraged?

- In your experience, do providers perceive that adolescents will be less likely to tolerate side effects from contraceptive methods? If so, how are these concerns dealt with?

- Have you had any experiences with the provision of postpartum contraception for teens? If so, have you faced any challenges?

- Do you perceive any state-specific challenges to serving the adolescent population?

- What have been some changes relating to adolescent sexual and reproductive health in the last couple of years?

- In what ways do these changes impact your day-to-day provision of care?

- How might the recently proposed changes to the Title X program impact how adolescents receive contraceptive services?

- Aside from health professionals like you, what role do you see for others like patient advocates, doulas, social workers, etc. in adolescents' experience receiving care?

Wrapping Up

- Is there anything else that we have not yet discussed that you would like to share?

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